# "They All Said You Could Come and Speak to Us"

**"They all said you could come and speak to us": Patients' expectations and experiences of help on an acute psychiatric inpatient ward**

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**Abstract**

**Background:** Acute psychiatric inpatient care forms an integral part of mental health services. Few studies have focussed on the patient experience of acute care. Research into patient experience is increasingly important to policy and service development processes. Knowledge of patient experiences facilitates the development of nursing practice.

**Aim of the Study:** To gain insight into the experience of being a patient on an acute inpatient psychiatric ward.

**Method:** 13 Participants were recruited from the acute ward. Unstructured interviews were used to gather narrative data of their experiences

**Analysis:** Holistic analysis of the narratives was informed by Gee's (1991) socio-linguistic theories that meaning is linked to narrative structure. Reading of the holistic analyses yielded themes of help, safety and power running across the participants' experiences.

**Findings:** The patient experience was characterised by dissonance between expectation and experience, the search for a nurse-patient relationship, and the development of strategies to cope with being on the acute ward. This paper focuses

on the theme of ‘Help’ where participants describe their expectation that they will receive help through the development of relationships with the nurses, and their experience of the barriers to this. In response, participants developed strategies to support each other.

**Accessible summary**

- Acute psychiatric inpatient care (acute care) is a part of the mental health care continuum. People are admitted to acute care when they are not able to be treated safely in the community.
- Interviews with 13 people who had been patients on an acute ward highlighted their expectation that they would receive help through talking with the nurses whilst on the ward.
- Participants were expected to ask for help from the nurses who said they could come and talk. They perceived that the nurses were always too busy to talk. Many of the tasks that the nurses were observed doing were perceived as ‘non nursing’ tasks.
- Participants supported each other because they didn’t feel they were getting the help they needed from the nurses. Whilst some participants reported this as helpful, others found it added to their emotional burden.

**Key Words:** Acute care; Patient experience; Narrative; Nurse-patient relationship

**Introduction**

Acute psychiatric inpatient wards (acute care) form an integral part of mental health services in Scotland, providing care for people whose mental health problems can no longer safely be treated in the community (Scottish Executive, 2006a). The role of the acute ward is defined within Scottish policy in both therapeutic and risk management terms (Scottish Executive, 2006a; Scottish Office, 1997). However, the need to manage risk has been identified as one of the main triggers for admission to acute care (Scottish Executive, 2006a; Bowers, 2005; Pilgrim, 2005).

There is a danger that risk management is becoming the *"sole focus"* (Scottish Executive, 2006b: 24) of nursing in acute care. Increased levels of acute illness influence the focus of nursing activity, as nurses strive to maintain the functioning of the ward in light of the unpredictable behaviours of its patients (Bjorkdahl et al, 2010; Deacon et al, 2006; Hall, 2004; Breeze & Repper, 1998; Bee et al, 2006). Risk management, rather than dealing with patient problems has become the focus of such ward management tasks (Radcliffe, 2006; Richards et al, 2005; Bee et al, 2006). The report of the review of mental health nursing in Scotland (Scottish Executive, 2006b) places the development of therapeutic relationships at the centre of mental health nursing.

Studies examining the focus of nursing activity on acute wards have highlighted the small proportion of time that nurses devote to therapeutically oriented face to face interaction with patients (Whittington & McLaughlin, 2000; Bee et al, 2006; Ford et al, 1998). Clarke and Flannagan (2003) observed the wide range of tasks, some of which were only loosely connected to patient care, that the nurses were expected to

undertake in order to keep the ward running. Such tasks necessarily become formalised into the ward routine, forming the discourse which makes the ward recognisable (Tilley, 1995). Such routine might be viewed as providing a refuge for those nurses who are *"failing to work therapeutically at an individual level"* (Howell & Norman ,2000: 607).

Studies examining patient experience have noted the impact of the nurses' focus on ward management tasks. Patients complain that the nurses spend a lot of time in the office doing paperwork (Sainsbury Centre for Mental Health, 1998; Higgins et al, 1999; Andes & Shattell, 2006; Rose, 2001), or being required to interrupt interactions with patients to undertake other ward tasks (Cleary & Edwards, 1999), making them inaccessible.

Such inaccessibility is identified as preventing the development of nurse-patient relationships in which the patient feels nurtured (Moyles, 2003). Coatsworth-Puspoky et al (2006) studied patterns of nurse-patient relationship formation, and identified a process of 'detrimental' relationship formation, characterised by barriers and mutual avoidance, linked to patients' perception that the nurses were inaccessible.

Few studies of acute care have focussed on the patient experience. Cutcliffe et al (2004) argue for the importance of researching patients' 'lived experience' of a particular phenomenon, asserting that this is necessary for healthcare workers to develop useful interventions. The findings of this study contribute to nurses' understanding of the patient experience facilitating the development of nursing practice.

**Researching patient experience**

> *"I cannot experience your experience. You cannot experience my experience. We are both invisible men. All men are invisible to one another. Experience used to be called The Soul. Experience as invisibility from man to man is at the same time more evident than anything.*
>
> Laing, 1967: 16

How experience is conceptualised has a direct bearing on the methods we use to 'know' others' experiences. Laing (1967: 16) highlights the fact that it is not possible simply to know another's experience through observation. If experience is invisible, then it is only knowable through representation. Narrative provides a vehicle for representing experience to self and others (Gee, 1985; Frank, 1995; Reissman, 1993).

Gee (2005; 1991) proposes that how we use language when forming narratives, allows us to create a version of reality, our experience, from a particular perspective. The meaning contained in narratives is therefore bound up with the structure that the individual gives them (Gee, 1991). Following this logic, narratives constructed in line with the narrator's concerns, and in their language, can be assumed to represent the narrator's experience. This premise underpins the design of this study.

**Methodology**

A qualitative design was chosen to investigate the main research question: *What is it like to be a patient on an acute psychiatric inpatient ward?*

Unstructured interviews were used to enable participants to structure their narratives how they chose, producing accounts that were close representations of their experience (Thomas & Pollio, 2002). The researcher adopted the stance of active listener, using probing questions and reflective statements arising from the participant's narratives to increase the depth of the data (Rosenthal, 2003). Using unstructured interviews in this way offered some protection against over-disclosure as it allowed participants to avoid or close down issues that they did not wish to discuss (Rosenthal, 2003). Despite this, recounting and reflecting on the meaning of their experiences might be distressing for participants (Shaw, 2003). This does not imply that the interview is harmful (Rosenthal, 2003; Corbin & Morse, 2003; Dench et al, 2004), indeed the opportunity to talk about their experiences can be beneficial to participants (Collins, 1998; Rosenthal, 2003; Corbin & Morse, 2001; Murray, 2003; Gair, 2002).

To facilitate in-depth accounts of their experience, data collection took place away from the hospital environment in a setting of the participant's choosing; all chose to be interviewed at home. Safety issues were considered as part of the ethical review process.

**Method**

**Participants**

13 participants (6 male, 7 female) aged 18 -65 years with a variety of diagnoses and numbers of hospital admissions took part in the study. Participants were recruited from an acute ward in a large psychiatric hospital serving an urban-rural area in Scotland between May and August 2006.

Nursing staff introduced the researcher to potential candidates. Patients were eligible for inclusion if they had the capacity to give informed consent; did not pose a risk of violence to the researcher; were not being held under a section of the Criminal Justice Act; had been in the ward one week or more. Patients who were agreeable met with the researcher to discuss the research, implications of participation for them and their families, and received written information. Verbal consent was gained from participants whilst they were on the ward. Participation in the study was confidential, and ward staff were not informed of who had agreed to take part.

The study was discussed with 16 patients; 15 agreed to participate. Two were then unavailable for interview and did not respond to further communication, so were excluded from the study.

**Data collection**

Participants were interviewed two and six weeks post discharge. The rapport developed during the first interview facilitated deeper exploration of the participant's experience (Hollway & Jefferson, 2000). Interviews lasted from 45 minutes to two hours.

**Data analysis**

All data were transcribed verbatim, and transcripts read and reread with the voice file to ensure best fit (Coates & Thornborrow, 1999). Following the first interview the transcripts were read and the main themes of the participant's narrative drawn out and summarised. This summary was sent to the participant and formed the basis of the second interview, providing the opportunity for clarification of misunderstandings and deeper exploration of the issues arising from the first interview.

After the second interviews, holistic analysis of the total data set for each participant was undertaken, guided by Gee's (1991) theories about how narrative structure creates meaning. From this analysis, poems were developed. Each poem embodies the researcher's understanding of what the participant was trying to convey about their experience of being a patient on the acute ward.

In order to identify the commonalities between the participants' experiences, the holistic analyses were examined and three themes that ran across the entire data set were identified. These themes were help, safety and power. In this article I have chosen to present findings relating to the theme of 'help'.

**Ethics**

Ethical permission was sought and granted through the NHS ethical review system. Participants were given written and verbal information about the study, and the opportunity to discuss the implications of participation for them and others close to

them with the researcher and an advocacy worker. Participation was voluntary. Written consent was gained. A list of support agencies was given to participants at interview. Pseudonyms were assigned to participants to maintain their anonymity. Data was treated in accordance with Data Protection legislation.

**Findings**

Admission to the acute ward created an expectation that participants would receive help with their problems. Participants expected this help to be available through interaction with the nurses. However, the nurses seemed to be too busy to spend time with them. To address this deficit the participants supported each other. However, whilst yielding benefits to some, this support also had a detrimental effect on those involved.

***"You have to come and find us"***

Participants expected the nurses to come and talk with them. However, the nurses did not generally approach them to talk, and this was interpreted as disinterest and a lack of caring. This experience resulted in a sense of alienation from the staff. Such alienation made it difficult to approach staff.

*"When I was in [name of other psychiatric hospital] the nurses there used to come and approach you …and took an interest in you, and you felt a bit more cared for in that respect."*

Robert

Several participants referred to instances when a nurse had spent time with them either listening to them, participating in social conversation, or participating in a

leisure activity with them. During these interactions participants felt supported and cared for. Such nurses were singled out for praise in their narratives.

*"She brought a chair and she said to me, 'you know, I've been so worried about you' ... You know I said, 'thank you so much'. Because, just for somebody to acknowledge that they had actually sussed* [how I felt]*"*

Jill

Participants described how, often after several days on the ward, they discovered that they had to take responsibility for seeking help from the nurses. However, they experienced a number of barriers to accessing the support they wanted from the nurses. Some participants described how their desire to be independent, or the loss of confidence caused by their illness, prevented them from asking for help. However, the most commonly cited barrier was the perception that the nurses were too busy.

***The nurses were too busy***

Participants remembered being told when admitted that they could come and talk to the nurses at any time. However, their experience was that the nurses were often too busy to talk. Participants found this situation particularly frustrating because of the expectations created by the nurses' initial statement of availability.

*"... I was told if I want somebody to speak to I'd get somebody to speak to. I mean we're not talking about when there's an admission coming in, or when somebody's kicking off. I'm talking about when there's no' much doing and you'd just like to talk to them, ken, just to try and explain what's happened."* (Ewan)

Participants' observations that the nurses were busy prevented them from asking for help. They referred to not wanting to increase the burden of stress placed on the nurses, or take up their time.

*"Cos you see them* [the nurses] *going about doing things…Sometimes I thought, ken, they're too busy to speak to you, so actually, I prefer them to come to me rather than having to go to them."* (Joanne)

Many of the tasks occupying the nurses were perceived as non-nursing tasks, preventing the nurses from performing their nursing role. Such tasks included updating files, administration, and housekeeping. Participants talked about the need to get administrators, or porters to take on some of this work to give the nurses more time to do their job. References were made to the burden of paperwork and staff shortages as a means of explaining this inaccessibility.

*"…if you dinnae bother them they dinnae bother you. I think it's like most hospitals, a shortage of staff."* (Josie)

Participants felt that they were taking up the nurses' time if they spent time talking with them. This led to feelings of guilt and frustration.

*"You have to fight for time with them, you have to fight for time with them, it's as if they're wanting to get away from you."* (Robert)

*"And eh, I'm an awful sensitive person and I felt worse after I'd talked to one of them because I got the feeling that I'd taken up too much of their time."* (Josie)

***Filling the void: supporting each other***

In response to their experiences of trying to get help from the nurses the participants described how they *"counselled"* each other. A sense of *"camaraderie"* was experienced as participants talked about their problems with one another.

*"Only patients get to know what is really wrong with people because nurses don't have time to spend getting to know them."* (Jennie)

*"In the smoking room, everybody comes into the smoking room and chats to each other, and I thought this was my therapy, yeah?"* (Connor)

The formation of supportive relationships with other patients was dependent on who was on the ward at the time; whether participants could relate to the other patients.

*"...we conversed, we just clicked, we were common interests or whatever."* (Amanda)

*"...the people on that ward at that particular time were quite violent...they weren't the kind of people I would normally go about with...I avoided them.."* (Becky)

Whilst many participants highlighted the positive nature of peer support, there were some negative aspects identified. The emotional needs of participants when on the ward resulted in the rapid formation of closeness within their relationships. This left them vulnerable to further emotional upset through the burden of taking on others' problems or when those with whom they were close were discharged, or died.

*"And that's* [supporting other patients] *exhausting, because you end up taking on a load of other people's problems"* (Jennie)

Thus, the development of peer support although beneficial, also had the potential to cause harm to those already feeling vulnerable.

**Discussion**

The findings highlight the dissonance between the expectations and the experience of participants in relation to getting help on the acute ward. Participants expected to receive help through interaction with the nurses but did not experience the relationship with the nurses that they had expected, or that fulfilled their needs. These findings resonate with those of previous studies (cf Moyles, 2003; Altschul, 1972; Cleary & Edwards, 1999; Bray, 1999; Higgins et al, 1999; Baker, 2002).

Participants' narratives about getting help on the acute ward focussed on the barriers they experienced when trying to access support from the nurses. Many of the participants described relationships reflecting the negative pattern described by Coatsworth-Puspoky et al (2006) who identified three phases that occurred in the nurse-patient relationship. The first phase, *withholding support* is identified through the participants' perception that the nurses were unavailable. The use of the term 'withholding' in the title of this phase points to an element of agency on behalf of the nurses; they choose not to offer support. This is perhaps most evident in the participants' statements that it was ward policy for nurses not to approach patients, and their experience of this as disinterest and a lack of caring.

During the middle phase patients avoid the nurses and perceive the nurses as avoiding them (Coatsworth-Puspoky et al, 2006). Within this study, as in others (Bee et al, 2006; Whittington & McLaughlin, 2000; Clarke & Flannagan, 2003), the nurses were observed to be undertaking a number of 'non-nursing' tasks which prevented them from spending time with patients. Absorption in these tasks offered the nurses a means of avoidance (Howell & Norman, 2000). Participants' development of mutual support gave them a means to avoid interaction with the nurses. Occupying the

smoke room, a *'free place'*(Goffman, 1961: 205) where patients are not constantly in the gaze of the nurses, and are therefore able to develop practices of resistance (Faubion, 2000) creates a barrier to interaction with the nurses (Skorpen et al, 2008)and is a further strategy of avoidance. Ironically, the strategies developed by participants to fill the void when they did not get the support they wanted from the nurses may have further diminished the opportunity for them to gain that support.

In the final phase patients attempt to rationalise the dissonance between their expectations and experience of their relationships with the nurses (Coatsworth-Puspoky et al, 2006). Within this study, participants drew on discourses of nursing shortages and an increasing administrative burden in their attempts to understand why they were not receiving the attention they expected.

Not all nurse-participant relationships followed this negative pattern. Participants identified particular nurses with whom they experienced positive relationships. Resonating with Moyles' (2003) findings, the defining characteristic of these positive relationships was the giving of time by the nurse. The giving of time made participants feel cared for. These relationships were described as one-off occurrences, where a nurse took time to be with a participant, taking an interest in them, listening to them. They resembled what Altschul (1972) identified as passing relationships, stopping short of categorisation as therapeutic relationships.

The dissonance between expectation and experience led the participants to develop strategies to deal with their situation through supporting each other. Group theorists have observed that in the face of adversity an assembly of people will

form a group, melded by a common purpose (Douglas, 1995, Thompson, 1999). Participants in Thomas et al's (2002) study of patients in an acute ward in the United States described their experience in terms of solidarity with other patients. Participants in this study experienced a similar sense, describing it as camaraderie. Such strategies however, left some participants feeling vulnerable. If the creation of mutual support networks alienated the nurses, this will increase the vulnerability of these patients.

**Implications for clinical practice**

The findings reported here have implications for the organisation and management of the acute ward, indicating the need to create space for nurses to spend time with patients. Following the completion of the study the researcher met with the ward managers who were already looking at making changes to ward practices, and interested to use the knowledge gained from this research to inform these. Further research drawing participants from wards in a number of different hospitals would offer more generalisable knowledge about the patient experience that could be used to inform ward organisation and practices.

The findings also indicate that nurses need to have an awareness of patient expectations and be aware of the need to manage these realistically so that patients do not feel frustrated. Such expectation management might be achieved through improved communication between nurses and patients. It is conceivable that the expectations of those who are admitted for the first time will differ from those with previous admissions. Further research would provide knowledge about these differences and how these might be addressed in the ward context.

## Strengths and limitations

The study was a qualitative study using a small, self selecting sample recruited from one particular hospital ward. The findings therefore have little generalisability across other contexts. Instead, the findings are considered to represent a snapshot of participants' experiences on one particular ward during one particular historical period. The value of such data is not in its ability to 'tell it how it is', but to *sensitise* the reader to the issues that are presented within the participants' narratives of their experience.

The involvement of ward staff in the selection of potential participants had the potential to create bias through their selection of some participants over others. However, this was necessary as it enabled the researcher to recruit only participants who were clinically well enough to be considered for participation (an ethical requirement of the study). The wide ranging experiences described by participants go some way to negating any argument that the sample was biased.

## Conclusion

The findings show the importance placed by participants on their relationship with the nurses in the acute care context. They perceive the development of a nurse-patient relationship, where they can spend time talking to the nurses about their problems as pivotal to the therapeutic potential of the acute ward. Central to the positive experience of these relationships are the actions of nurses to initiate interaction with patients, and the making of time for patients.

The participants' concept of mental health nursing is congruent with that of nurse theorists (Peplau, 1988; Altschul, 1997; Barker et al, 1999), and resonates with the current policy-makers' vision of mental health nursing (Scottish Executive, 2006b). Despite the seeming alignment of expectations and attitudes between policy makers, nurses and patients, the findings of this study identify dissonance between participants' expectation and experience. This finding is supported by the findings of other studies from as far back as three decades ago (Altschul, 1972), as well as findings from international studies (cf Thomas et al,, 2002; Cleary & Edwards, 1999). Such evidence indicates a need to examine the impact of the political and social context on mental health nursing and the development of nurse-patient relationships.

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